rather pale and flabby and had a slight cough. Santonin powders of three grains each were ordered to be taken fasting on alternate mornings for three days, preceded on the previous night by castor oil and followed by a similar dose. She had a dose of castor oil on the night of April 21st and her first powder at 7 A.M. on the 22d. On this occasion the only sign of any eruption was a red œdematous patch the size of a five-shilling piece on the left forearm, which was rather irritable and was ascribed by the mother to an insect bite. On the 24th she had the second powder at 7 A.M., and by 8 A.M. the face was red and puffy, and in a short time the whole body and the limbs were œdematous and covered with a typical urticarial eruption, consisting of large white wheals surrounded by a broad, red areola. There was some irritation, but it was not at all intense, and by 11 A.M. the rash had almost entirely disappeared. To verify the cause the third powder was given at 7.20 A.M. on the following day, and in an hour a similar rash, if anything more intense, had appeared. The bowels were freely opened about 9 A.M., and the rash had entirely gone by 10 A.M.

Sieveking (*Brit. Med. Journ.*, February 18, 1871) mentions a similar example, and Morrow, in his work on drug eruptions, quotes a number of cases recorded by Hubert, in which the administration of santoninate of soda was followed by an eruption of pin-sized vesicles on the trunk and limbs. It appears, therefore, that the santonin idiosyncrasy is rare, and that the eruption may vary in character, is accompanied by little or no constitutional disturbance, and rapidly disappears, leaving no ill-effects.

THE STARTING-POINTS OF TUBERCULOUS DISEASE IN CHILDREN.

J. WALTER CARR (*Lancet*, May 12, 1894, p. 1177) presents an interesting paper under this title founded upon the records of 120 necropsies made at the Victoria Hospital, Chelsea, upon children suffering from tuberculous lesions, in no less than 82 of which the disease was more or less generalized. The most important general conclusions are these: 1. That tuberculous disease in children commences usually in the glands, the liability being at its maximum during infancy and early childhood, and rapidly decreasing in later childhood. That caseous glands, especially the internal ones, may (*a*) remain quiescent for an indefinite period; (*b*) start tuberculous mischief in adjacent parts, especially the lungs, by direct extension; and (*c*) set up general miliary tuberculosis. 2. That the internal glands, at any rate, are probably most often infected directly from the organ with which they are connected, although the possibility of infection through the blood-stream must not be forgotten. 3. That tuberculous disease starts much more frequently in the thorax than in the abdomen, and certainly far more often in the thoracic than in the mesenteric glands. This does not throw any doubt upon milk as a possible source of tuberculous disease, but this does not seem to be by any means a frequent mode of infection as compared with that through the lungs. At the same time the importance attached by Dr. Woodhead, on the basis of his statistics, to the mesenteric glands, indicates the necessity of a further and prolonged investigation of the pathological evidence, not in one place only, but in all parts of the country—for the conditions producing tuberculous disease may vary materially in different localities. 4. That glandular disease may often exist alone and quite unsuspected; in very many cases, doubtless, it is quite impossible of diagnosis. 5. But, after all, by far the most important treatment is the prophylactic. Whether the glands get infected directly through the lymphatic channels or indirectly through the blood-stream, the organisms must in every case have passed in through the mucous membrane, and through a healthy one they probably cannot penetrate. We have, therefore, to try to prevent gastro-intestinal and respiratory catarrhs, and especially to avoid their becoming chronic; to deal promptly with, and if possible to prevent, rickets, the great cause of such catarrhs in early childhood; and to take especial care of children during convalescence from measles, whooping-cough, and other acute specific diseases, so liable to depress the vitality of the body generally, and the resistant power of the mucous membranes, as well as the filtering power of the glands, in particular.

PRIMARY SARCOMA OF THE SUPRA-RENAL CAPSULE IN AN INFANT.

COHN (*Berliner klinische Wochenschrift*, 1894, No. 11, p. 257) reports an interesting case of the kind in a girl of nine months. She was brought to the clinic for a tumor of the right temporal region with exophthalmos of the right globe. Examination showed a diffuse tumor of the temporal region limited in front by the external margin of the orbit and behind by the ear. The mass was adherent to the underlying tissue and was covered by movable but highly vascularized skin. Some similar nodules were found behind the ear and upon the vertex. The right eye was very prominent. The liver was considerably enlarged, and a little below it, but not connected with it, was a round tumor. The spleen was also slightly enlarged.

The diagnosis was neoplasm of the kidney with multiple metastases. During the three weeks following, the tumor of the temporal region grew very rapidly and invaded the nasal fossæ and the palate; the abdominal tumor had increased posteriorly and become prominent in the lumbar region.

At the autopsy a medullary sarcoma of the right supra-renal capsule was found, with metastases in the liver, the kidneys, and the ribs at the costochondral junctions.

A PECULIAR SYNDROME IN TUBERCULOUS CHILDREN.

WEILL (*Lyon Médical*, 1894, Nos. 20 and 21, p. 77) calls attention to a peculiar association of symptoms which he has observed in several cases of pulmonary tuberculosis in children. This is characterized by cyanosis of the face and extremities, a sensation of coldness coincident with a notable depression of the central and peripheral temperature, arterial spasm, increase in the number of red corpuscles in the cyanotic areas, increase in the size of the spleen, and transitory albuminuria. This syndrome is produced simply by a change of posture from the recumbent to the standing, or by passage from a warm temperature to a moderate or a cool temperature. The phenomenon is transitory, its duration varying from several minutes to several hours. It has an intermittent course, being produced very easily at certain periods and not showing itself at others. It appears to be independent of the clinical aspect of the pulmonary tuberculosis, of the predominance of any symptom,